CHAPTER Ins 2200 HEALTH MAINTENANCE ORGANIZATIONS

Statutory Authority: RSA 400-A:15; RSA 420-B:21

PART Ins 2201 DOMESTIC HEALTH CARE ORGANIZATIONS

Ins 2201.01 RESERVED

Ins 2201.02 Definitions.

(a) For the purposes of this part, the definitions appearing under RSA 420-B:1 shall apply whenever any word or phrase defined under RSA 420-B:1 is used in this part.

(b) With respect to the following words or phrases used in this part, but which are not defined under RSA 420-B:1, the following definitions shall apply:

(1) "Active recipient of mental health services" means an insured, subscriber or member of a replacing carrier's health insurance benefit plan who received mental health services from a mental health provider while covered by a prior carrier's benefit plan provided such services were for a purpose other than monitoring medications and were received at least as often as:

a. In the case of outpatient services:

1. For 2 separate days during the 30 day period immediately prior to the effective date of the replacing carrier's plan; or

2. For 3 separate days during the 90 day period immediately prior to the effective date of the replacing carrier's plan; or

3. For 5 separate days within the 12 month period immediately preceding the effective date of the replacing carrier's plan; and

b. In the case of inpatient services, one inpatient confinement during the 12 month period immediately prior to the effective date of the replacing carrier's plan.

(2) "Mental health provider" means any professional or institution listed under RSA 415:18-a, IV.

Source. #1900, eff 1-1-82; ss by #4287, eff 7-1-87; ss by #5655, eff 7-1-93; amd by #5944, eff 1-1-95; ss by #7018, INTERIM, eff 7-1-99, EXPIRES: 10-29-99

Ins 2201.03 Applicability.

(a) No health maintenance organization may provide or arrange for health care service to enrolled participants in exchange primarily for a prepaid per capita or aggregate fixed sum without being licensed in accordance with the provisions of these parts prior to commencing operations except as provided in Ins 2201.04. Commencing operations shall occur on that date on which any contracts for health services are available to members or on which evidences of coverage are issued.

(b) This part applies to any such health maintenance organization regardless of whether services are to be delivered through physicians or other health professionals:

(1) Who are employees of the health maintenance organization;

(2) Who are organized on a group practice basis;

(3) Who are organized on an individual practice basis; or

(4) Under any other arrangements.

Source. #1900, eff 1-1-82; ss by #4287, eff 7-1-87; ss by #5655, eff 7-1-93; ss by #7018, INTERIM, eff 7-1-99, EXPIRES: 10-29-99

Ins 2201.04 Certificate of Authority.

(a) Any health maintenance organization covered by Ins 2201.03(b)(1) of this part must submit an application for a certificate of authority as a health maintenance organization by filing an original and 2 copies of the following documents:

(1) If the applicant is not domiciled in this state, a power of attorney duly executed and appointing the commissioner and his successors in office, and duly authorized deputies, as true and lawful attorney for the applicant for service of process in this state pursuant to RSA 420-B:4;

(2) Payment by check or other draft of required application fees as set forth in RSA 400-A:29;

(3) Basic organizational documents, articles of incorporation, etc., and all amendments thereto;

(4) Copies of all by-laws, rules and regulations of the applicant;

(5) Copies of the organizational chart of the applicant, including the titles, names, and salaries, if any, of officers and key management personnel dealing in marketing, administration, enrollment, grievance procedures, quality assurance, contract negotiations, and financial matters;

(6) A list of members of the board of directors, or similar policymaking body of the applicant, with the name, principal occupation, and employer of each;

(7) A description of the applicant's proposed system for handling complaints. Such description shall include procedures for the registration of complaints and procedures for the resolution of complaints;

(8) Financial reports for the prior 3 fiscal years of the applicant's existence. Reports submitted by insurance companies or hospital, medical, or health service corporations applying for a certificate of authority to operate a health maintenance organization as a subsidiary or affiliate pursuant to RSA 420-B:19 shall be restricted in subject matter to the finances of such subsidiary or affiliate; and

(9) Financial statements projecting the results of the applicant's operations for the next 3 years from the date of application, on a quarterly basis for years one and 2 annually for year 3. Such financial statements shall include the following:

a. Balance sheet;

b. Statement of income from all sources, and expenses;

c. Cash flow;

d. Present and anticipated capital expenditures;

e. Repayment schedules for existing or anticipated loans or alternative financing arrangements;

f. Statement indicating when the applicant estimates that income from enrollments and other operations will equal expenses; and

g. Accompanying the financial report must be detailed statements underlying assumptions used and the bases thereof.

(10) A detailed statement of the health maintenance organization's plan to establish and maintain reserves or other funds as determined necessary to cover any risks projected and not otherwise assumed by another entity, carrier or reinsurer, and a detailed statement of current and projected reserve-establishment calculations, as well as amounts, purpose and uses of the reserves, and assumptions and bases therefor, including, but not limited to, identification of reserves set aside to meet uncovered reinsurance items.

(11) Copies of all reinsurance, conversion, or other arrangements with other insurers, health providers, medical service corporations, hospital service corporations, health service corporations, governmental agencies or organizations or other health maintenance organizations to provide payment for the cost of contracted-for health care services, or to directly provide such services, in the event the health maintenance organization is unable or ceases to provide contracted-for health services for any reason.

(12) A copy of the applicant's official notification of status as a federally qualified health maintenance organization, if it is so designated.

(13) A statement of insurance or funded self-insurance for protection against loss of property and liability of the application; workmen's compensation to protect against claims arising from work-related injuries of the applicant's employees; and medical malpractice liability insurance of the applicant and its providers.

(14) A listing of shareholders or other equity holders, or members with holdings of 5 percent or more of capital shares, partnership interest, or other evidence of equity holdings. Such listing shall be by name, address, number and percentage of shares or other interest held, and any other affiliations with the applicant.

(15) A listing of the applicant's legal, accounting, and actuarial representatives by name and address.

(16) A statement for fidelity bond coverage of all officers and employees entrusted with the handling of funds for the applicant.

(17) A statement of enrollment practices and procedures.

(18) An enrollment member-month projection for the next 3 years from the date of application, on a quarterly basis for years one and 2, and annually for year 3. Such projection shall be of total enrollment of the application, as well as for the following categories of membership; private, group, non-group, medicaid, medicare, federal employees, and state employees. Projections should be accompanied by a detailed statement of assumptions used, and the bases therefor.

(19) A description of the geographical area to be served, including present population figures for each city or town within the current area. The description shall also include projections of future population trends for each city and town within the current area for the next 5 years from the date of application.

(20) The application should be compiled in the order of the items required. Where items are not included in the application, the applicant must state the reasons for such absence.

(21) In the event the commissioner finds the application incomplete, he shall give the applicant written notice to that effect and shall specify the additional documents or information required under this part. The applicant shall file the additional material required within 30 days of its receipt of the notice. If the applicant is not so completed within 30 days after notice by the commissioner, then the applications shall be deemed rejected.

(b) An applicant, prior to the issuance of a certificate of authority to operate a health maintenance organization, may engage in such activities as are necessary to the gathering of information for applications for certification as a federally qualified health maintenance organization, and for certification pursuant to RSA 420-B and these parts. An applicant may also make contact with potential enrolled participants and/or their employers for the purposes of determining the feasibility of establishing a health maintenance organization in a given area, and for the purpose of generally acquainting the potential enrolled participants and/or their employers with the general benefits of the applicant's proposed program. In no event, may there be a commitment to render services on the part of the applicant, or the initiation of a contract between the applicant and enrolled participants and/or their employers. An applicant may also engage in such activities as are necessary to the establishment of physical facilities for the operation of the health maintenance organization should its application be eventually approved. This authority is granted at the discretion of the commissioner, and may be revoked at any time.

(c) Any health maintenance organization operating prior to the effective date of RSA 420-B must file an application with 120 days of the effective date of such chapter, or within 90 days of the effective date of this part, whichever comes later, and such company may continue to operate until such time as its application may be denied. Such a company shall not be subject to the restrictions of Ins 2201.04(b) above, of this part unless it has failed to file an application within the time limits set forth in Ins 2201.04(b) of this part.

(d) Before issuing a certificate of authority to an applicant, the commissioner shall be satisfied, by such examination as he may make and from such evidence as he may require, that the applicant has complied, and will continue to comply with the requirements of RSA 420-B and this part, and:

(1) The commissioner shall act upon the application for a certificate of authority within 90 days after the filing of a completed application.

(e) Denial of certificates of authority.

(1) The commissioner shall review an application for a certificate of authority, and if he is not satisfied by such examination as he shall make and from such evidence as he may require:

a. That the applicant is safe, reliable, entitled to confidence, and in sound financial condition; and

b. That the issuing of a certificate of authority would not be in the public interest, the certificate of authority shall be denied. The commissioner shall notify the applicant, in writing, of such denial, stating the reasons therefor.

(2) If the applicant wishes a hearing before the commissioner concerning the denial of the certificate of authority, it may make an application for such hearing pursuant to RSA 400-A:17. The hearing will be conducted according to the provisions of RSA 400-A.

(f) Each certificate of authority issued under this part shall remain in effect until revoked or suspended by the commissioner, provided the health maintenance organization commences operations within one year after the date on which the certificate of authority was issued. Failure to commence operations within that period invalidates the certificate of authority and a new application must be submitted before another certificate of authority will be issued.

(g) Grounds for revocation or suspension of certificate of authority include:

(1) If the commissioner is satisfied, upon examination or from other evidence submitted to him, that any health maintenance organization is in an unsound financial condition, or that its business policies or methods are unsound or improper, or that its condition or management is such as to render its further transaction of business hazardous to the public or to its members, or that it is committing prohibited acts pursuant to RSA 420-B:12, or that its officers or agents have refused to submit to an examination as provided for in RSA 420-B:10, or that it has violated any provision of law or part he may take any one, or any combination of the following actions:

a. Revoke the certificate of authority;

b. Suspend the certificate of authority for any definite or indefinite period of time;

c. Restrict the certificate of authority so that the health maintenance organization may only service existing business and may not enroll any new participants; or

d. Require the health maintenance organization to make a deposit of cash or securities with the commissioner for the exclusive benefit of New Hampshire participants; or

e. Require that action be taken by the health maintenance organization to correct the conditions found.

(2) Before any of the actions set forth in ins 2201.04(e)(1) are taken, the commissioner shall notify the health maintenance organization in writing of his intention to revoke, suspend or

restrict the certificate of authority or to require a deposit, or to require certain actions to be taken to correct the conditions found,
and such notification shall state the reasons for the action. If the commissioner finds that an emergency exists requiring immediate action, he may order suspension of the certificate of authority of the health maintenance organization, pending further proceedings in accordance with this part.

(3) If, following notification by the commissioner of his intention to require that actions be taken to correct conditions found, the health maintenance organization does not take such corrective measures within the time limits established by the commissioner, the commissioner may notify the health maintenance organization of his intention to take other action under Ins 2201.04(e)(1).

(4) If the health maintenance organization wishes a hearing before the commissioner concerning any such action or notification of intent to act, it may make an application for such hearing pursuant to RSA 400-A:17. The hearing will be conducted according to the provisions of RSA 400-A.

Source. #1900, eff 1-1-82; ss by #4287, eff 7-1-87; ss by #5655, eff 7-1-93; ss by #7018, INTERIM, eff 7-1-99, EXPIRES: 10-29-99

Ins 2201.05 Rate Standards and Filing.

(a) Rate filings shall be examined by the commissioner to determine whether the rates are reasonable in relation to the benefits and health care services provided and not excessive, inadequate or discriminatory.

(b) Rate filing procedures include:

(1) Rates applicable to any evidence of coverage must be filed with the commissioner for approval before the evidence of coverage may be issued to enrolled participants;

(2) The following data is required by the commissioner with each rate filing and should be broken down by the type of filing, all proposed rate sheets should be filed on 8-1/2 x 11 inch sheets with the name and address of the company appearing on the rate sheet:

a. For new filings an actuarial memorandum should be submitted describing how premium rates were computed. The memorandum should include suitable date indicating the basis for the rates, such as the expected claim costs, the tables of experience, if any, upon which the rates have been based and an explanation of how the premium rates were obtained, including expense assumptions wherever applicable. When modifications have been based on judgment, this should be indicated as well as any other relevant information which the company feels is appropriate;

b. For revision of current rates on existing evidences of coverage a memorandum should be submitted setting forth the reason and nature of the revision. In addition, the memorandum should state the detailed areas revised, the existing rates, the
revised rates, an estimate as to the percentage and aggregate expected average increase or decrease in premiums, the recent experience under existing rates showing premiums on an earned basis and showing losses on a paid and an incurred basis. Such experience should cover the period from the date of the last premium revision or evidence of coverage

approval to the present. Additional pertinent information may be requested when the increase is substantial in amount, or when other circumstances are unusual; and

c. The commissioner will examine requests for rate increases on an individual basis as appropriate. It is realized that there are many factors relative to a determination of a reasonable loss ratio on any given coverage. Some of the factors are type of coverage; level of premiums; loss ratio trends; expenses; statistical significance of experience figures in each rating category; nature of guarantees; previous history of dividend distribution an absolute size of the most recent loss ratios.

(c) Review and approval of rate filings shall be conducted pursuant to RSA 400-A, and appeals therefrom shall be made in accordance with RSA 541.

Source. #1900, eff 1-1-82; ss by #4287, eff 7-1-87; ss by #5655, eff 7-1-93; ss by #7018, INTERIM, eff 7-1-99, EXPIRES: 10-29-99

Ins 2201.06 Evidences of Coverage and Advertising.

(a) Form filing and review procedures for evidences of coverage include:

(1) Evidences of coverage, their amendments, and forms to be used in connection therewith must, prior to their issuance to any person in this state, be filed with and approved by the commissioner. Included with the filing there should be one self-addressed, stamped envelope;

(2) The health maintenance organization making the filing shall submit a letter of transmittal, signed by a representative of the health maintenance organization authorized to submit filings, containing at least the following:

a. A complete list identifying by number and title each form submitted, such listing to be placed either in the subject heading of the transmittal letter or an attachment;

b. A brief description of the form, any new or unusual features, and forms to which it will be attached; and

c. If the submitted form is replacing another form, said other form should be identified. If the submitted form is not replacing another form, such fact should be so stated.

(3) Submitted forms shall be filled out in "John Doe" fashion where appropriate.

(4) In order that forms may be given due consideration and any defects therein pointed out and corrected before it is printed for formal submission, a health maintenance organization may submit printer's proofs of such form for tentative approval. If other than printer's proofs are submitted, the copies must be clearly legible. Typewritten copies prepared by a legible duplicating process may be submitted for documents to be issued in connection only with single cases, or when their use will be too infrequent to justify other preparation.

(5) The commissioner cannot consider for formal approval any form which has been modified by typewritten, ink, or other insertion or deletions. Such changes should be made by printed,

multigraph or rubber-stamp endorsement properly executed by a duly authorized representative of the health maintenance organization.

(6) The commissioner is concerned with complete evidences of coverage and related forms. Such forms, therefore, should be filed as intended for use, with all necessary related forms and documents, including "John Doe" application forms. Where amendatory pages are submitted, such pages must be properly executed as such. However, riders and endorsements to be used with existing evidences of coverage may be filed independently. This practice does not preclude the use of variable fill-in material, properly specifying the variable language to be employed. In all other cases, the complete revised form, including such amendments must be submitted with a distinguishing form number, as provided in Ins 2201.06(b).

(7) All evidences of coverage submitted must be in final print except manuscript group evidences of coverage which are to be written on a one-case basis only. In such a case, the letter of transmittal must specify that the manuscript evidence of coverage is to be used as a one-case basis if the evidence of coverage is to be considered as a manuscript evidence of coverage. All certificates of any group evidences of coverage must always be in final printed copy. Evidences of coverage and certificates may be reviewed in proof form if the transmittal letter indicates the health maintenance organization tentative approval prior to final print, as provided in Ins 2201.06(a)(4).

(8) Forms must be submitted with the exact contract as intended for use by the health maintenance organization and must bear facsimile signatures of the organization officers. Facsimile signatures, however, will not be required on group certificates.

(9) Because of the many variations possible, group evidences of coverage, their certificates and all of the intended insert pages reflecting possible variations will be accepted for approval, provided that such filing is accompanied by a statement describing the combination of pages that will be used for the different types of evidences of coverage. Whenever applicable, every filing of a group of evidence of coverage or group page must include the simultaneous filing of the corresponding group certificate page. In addition,
every filing of a group certificate or group certificate page must include the simultaneous filing of the corresponding group evidence of coverage or group page. If, however, the form corresponding to the group form being filed has been previously submitted and/or filed, reference to that form in the transmittal letter will be sufficient.

(10) Any submission of a "blank" rider, amendment, or endorsement form shall in all instances be accompanied by a listing of all intended uses.

(11) In the event that forms submitted to the commissioner by an insurer are not approved, and such forms are thereafter corrected and resubmitted, then the transmittal letter for the resubmission shall be in duplicate, shall contain a listing of all the forms resubmitted in the manner specified in Ins 2201.06(2)(b) and shall describe each correction made in the resubmitted filing.

(b) General document standards for evidences of coverage include:

(1) Each form for an evidence of coverage must be designated by a suitable form number, which may be made up of numerical digits or letters, or both, in the lower left-hand corner of each form. This form number should be sufficient to identify any given form from all others used by the

health maintenance organization. No additional numbers which could be construed as form numbers may appear elsewhere at the bottom of the forms on the left, except the prefix "Form No.". No other state's abbreviation may follow a form number unless this state's abbreviation, N.H., also appears; and

a. A reprinted form where any changes have been made, must be resubmitted as a new form with a new form number.

(2) Every evidence of coverage shall recite the full corporate or legal title of the health maintenance organization. The official home office address, city and state, shall appear on the face, or on the back of the specifications page. If administrative offices are maintained elsewhere, such other addresses may also be shown.

(3) A brief description of the nature of the evidence of coverage must be printed at the top or bottom of the first page of the evidence of coverage form or on the filing back, if any, except that this description may appear on the specifications page in the case of window-type evidences of coverage, evidences of coverage in booklet form, or evidences of coverage utilizing a half-sheet or smaller first page, provided that the brief description must be visible to anyone viewing the first page of the evidence of coverage. A statement must be included in the brief description indicating whether the evidence of coverage is participating or nonparticipating.

(4) The words "preferred", "special", "unlimited", "union", "labor", "New Hampshire", or any words or combinations of words shall not be used in any way which might reasonably cause anyone to believe that he is receiving or will receive preferential treatment unless he is, in fact, receiving preferential treatment, or will receive preferential treatment.

(5) The word "compensation" shall not be used in any way which might reasonably cause the policyholder to be confused with workmen's compensation coverage.

(6) The words "insurance", "casualty", "surety", "mutual", or any other words descriptive of the insurance, casualty, or surety business or deceptively similar to the name or description of any insurance or surety corporation doing business in this state shall not be used in the evidence of coverage of any health maintenance organization, except by one which is licensed as an insurer.

(7) If the evidence of coverage contains an exception for injury arising out of riots, the exception should be confined to those instances in which the insured is injured while participating in such riot.

(8) Any evidence of coverage, which contains unusual exclusions, limitations, reductions, or conditions of such a restrictive nature that the payment of benefits under such evidence of coverage is limited in frequency or in amounts, should carry the legend "This is A Limited Evidence of Coverage-Read It Carefully" imprinted in not less than 18-point outline type of contrasting color or not less than 24-point outline type of non-contrasting color diagonally across the face and filing back, if any, of the evidence of coverage.

(9) The word "medicare" or any combination of words shall not be used in any way which might reasonably cause anyone to believe that he is participating in a governmental program.

(10) Except as otherwise specifically provided in New Hampshire statutes or this part, any evidence of coverage issued, delivered, used or sold in this state in violation of any of the

provisions of New Hampshire statutes or this part shall be valid and binding upon the health maintenance organization making or issuing the same, but in all respects in which its provisions are in violation of the requirements or prohibitions of New Hampshire statutes or this part, it shall be enforceable as if it conformed with such requirements or prohibitions.

(11) The phrases "caused directly or indirectly" or "resulting wholly or in part from" or any substantially similar phrases are not to be included in the provisions of any evidence of coverage which sets forth exclusions or exceptions from coverage due to a specified cause.

(12) All forms of evidence of coverage issued by a health maintenance organization to enrolled participants, or other marketing documents purporting to describe the organization's health care services shall contain clear and complete information indicating:

a. The health care services and other benefits to which the enrolled participant is entitled;

b. Any exclusions or any limitations on services or any other benefits to be provided, including any deductible or copayment feature or any restriction relating to preexisting conditions;

c. Where and in what manner information is available as to how services may be obtained;

d. The predetermined periodic rate of payment for health care services and other benefits and other charges, if any, which the enrolled participant is obliged to pay; and

e. All criteria relating to disenrollment or denials or re-enrollment.

(c) Filing procedures and standards for advertising include:

(1) Before any form of advertising or other document used regularly in marketing or acquainting the public with the benefits and services of a health maintenance organization may be so utilized in this state, it must first be filed with the commissioner for approval. The filing of such advertising material shall be accompanied by a transmittal letter stating the purpose of the filing, and the type of use to which the materials will be put.

(2) Advertising used by the health maintenance organization shall not be untrue, misleading or deceptive as defined in RSA 420-B:12. It shall contain such information as is necessary to apprise the persons who are exposed to it of the area of coverage of the organization, its general benefits offered, and where the information may be obtained as to how services may be obtained.

(3) The submission of advertising forms shall be as printer's proofs, as they would be used by the organization and viewed by the public if approved for use. The advertising shall also contain in its lower left-hand corner a distinguishing form number made up of digits or letters, or both, sufficient to identify the form submitted from all others used by the health maintenance organization. No other figures shall appear in the lower left of such advertising submittal except the prefix "Form No." No other state's abbreviation can follow a form number unless this state's abbreviation, N.H., also appears. Where changes have been made on a reprinted form, a resubmission must be made as a new form, with a new form number.

Source. #1900, eff 1-1-82; ss by #4287, eff 7-1-87; ss by #5655, eff 7-1-93; ss by #7018, INTERIM, eff 7-1-99, EXPIRES: 10-29-99

Ins 2201.07 Periodic and Special Reporting.

(a) The health maintenance organization shall give notice to the commissioner of the happening of the events listed below, concurrently with their occurrence:

(1) Plans to purchase, lease, construct, renovate, operate, or maintain medical facilities;

(2) Any loans with an annual aggregate from one creditor exceeding one percent of the health maintenance organization's liabilities, including the amount of such loans, the terms of repayment, security given, if any, and guarantees or sureties provided, if any;

(3) Any contracts entered into with an insurance company or health service corporation, excluding contracts for fringe benefits for organization employees, including copies thereof; and

(4) Any grants to be received from sources either public or private, exceeding on an annual aggregate basis from one source one percent of the health maintenance organization's assets.

(b) The health maintenance organization shall give monthly reports to the commissioner concerning membership changes in group and non-group categories.

(c) Changes in controlling interest filing include:

(1) Every health maintenance organization must file with the commissioner, within 30 days of occurrence, a report of all changes in controlling interest of the health maintenance organization, in a form prescribed by the commissioner; and

(2) "Controlling interest" as used above, means the possession, either directly or indirectly, of the power of a person or persons to direct or cause the direction of the management and policies of the health maintenance organization, whether through the ownership of voting stock, or by contract, other than commercial contract for goods or management services, or through official position or positions of, or corporate office or offices held by, the person or persons, or otherwise. Controlling interest shall also be presumed to exist if any person, directly or indirectly, owns, controls, holds, with the present power to vote more than 5 percent of the voting stock of the health maintenance organization, or holds proxies representing more than 5 percent of the voting stock of any other person or persons.

(d) Each health maintenance organization shall, within 5 business days after the occurrence, inform the commissioner of any extraordinary loss or claim which has the potential to render it incapable of meeting its obligations as they become due.

Source. #1900, eff 1-1-82; ss by #4287, eff 7-1-87; ss by #5655, eff 7-1-93; ss by #7018, INTERIM, eff 7-1-99, EXPIRES: 10-29-99

Ins 2201.08 Annual Reports.

(a) Every health maintenance organization shall annually file with the commissioner and with the commissioner of health and welfare, within 120 days after the close of its fiscal year, 3 copies of a report, verified by an appropriate official of the organization, showing the health maintenance organization's financial condition on the last day of the preceding fiscal year.

(b) Each health maintenance organization shall submit the following materials to the commissioner as documentation of its annual report:

(1) A financial statement, to be either in the form of the National Association of Insurance Commissioners, NAIC, blank accompanied by a statement certified by an independent public accountant, or in the form of the NAIC blank itself certified by an independent public accountant;

(2) Any changes, occurring during the preceding fiscal year, in information which had been submitted with the health maintenance organization's application for a certificate of authority;

(3) Details of services provided by the health maintenance organization of a fee-for-service or charitable basis;

(4) A listing of all complaints received by the health maintenance organization from members during the period of the preceding fiscal year, with a description of the complaint, and how it was resolved. "Complaints" as used above means the grievances of persons concerning the services of the organization or the method of delivery of such services, and shall not include in any case frivolous or inconsequential grievances; and

(5) A statement of all investments made by the health maintenance organization, as provided for in the NAIC blank form referred to in Ins 2201.08(b)(1).

Source. #1900, eff 1-1-82; ss by #4287, eff 7-1-87; ss by #5655, eff 7-1-93; ss by #7018, INTERIM, eff 7-1-99, EXPIRES: 10-29-99

Ins 2201.09 Licensing of Agents.

(a) All agents of health maintenance organizations shall, prior to acting in such capacity, be licensed by the commissioner in the manner set forth in this section. No unlicensed agents shall be permitted to solicit or sell any health maintenance organization benefits more than 30 days after the effective date of these parts.

(b) Pursuant to RSA 402:15, only residents of this state or residents in any other state granting similar licenses shall be eligible to receive licenses as agents for health maintenance organizations.

(c) Upon written notice by a health maintenance organization of its appointment of a person to act as its agent in this state, the commissioner shall, if he is first satisfied that the appointee is a suitable person and intends to hold himself out in good faith as an agent for a health maintenance organization, subject the appointee to a written examination on his qualifications to act as an agent. If the commissioner, after such examination, is satisfied that the appointee is qualified by instruction or experience to act competently as an agent in all respects, the commissioner shall issue to the appointee a license which shall state in substance that the health maintenance organization is authorized to do business in this state and that the person named therein is the constituted agent of health maintenance organization for the purposes set forth in said license.

(d) Appointees and licensed agents of health maintenance organizations shall pay the following fees to the commissioner, in accordance with RSA 400-A:29:

(1) Application and examination fee of $15.00, which fee is not refundable;

(2) Original licensing fee of $10.00, for a 2 year term; and

(3) Renewal licensing fee of $10.00, for a 2 year term.

(e) Unless revoked by the commissioner, or unless the health maintenance organization, by written notice to the commissioner, cancels the agent's authority to act for it, such liens or renewal of it shall expire on the 15th day of June of the second year after the issuance of the license or renewal.

(f) In all cases, the licensing of agents for health maintenance organizations shall be governed by the provisions of RSA 402:15-26 relating to the licensing of agents for accident and health insurance companies, as such statute may be amended from time to time.

Source. #1900, eff 1-1-82; ss by #4287, eff 7-1-87; ss by #5655, eff 7-1-93; ss by #7018, INTERIM, eff 7-1-99, EXPIRES: 10-29-99

Ins 2201.10 Federal Legislation and Regulation. It shall be incumbent upon the health maintenance organization to provide, within a reasonable period after enactment, the commissioner with copies of all federal legislation and regulations pertaining to health maintenance organizations, and a statement as to the effect of that legislation or regulation on the health maintenance organization.

Source. #1900, eff 1-1-82; ss by #4287, eff 7-1-87; ss by #5655, eff 7-1-93; ss by #7018, INTERIM, eff 7-1-99, EXPIRES: 10-29-99

Ins 2201.11 Continuity of Benefits.

(a) The transition, under the employment-related group health insurance plan, from a traditional indemnity or nonprofit health service corporation mode of coverage to a health maintenance organization shall be effected in every case without application of waiting periods or exclusions or limitations based on health status as conditions of enrollment or transfer and shall provide all basic health services, as defined in section 1302(1) of the Health Maintenance Organization Act of 1973 (42USCA 300e-1(1) as amended, that exist under the applicable traditional indemnity or nonprofit health service corporation mode of coverage from which transfer is made.

(b) Whenever there is a replacement of a carrier's benefit plan by the benefit plan of another carrier, the insureds, subscribers or members who were active recipients of mental health services under the prior carrier's plan shall be entitled to continue to receive mental health services from the same mental health provider who provided the services received while the insured, subscriber or member was an active recipient of mental health services under the prior carrier's plan.

(c) The entitlement to receive services pursuant to (b) above shall:

(1) Continue for one year following the effective date of the new carrier's benefit plan;

(2) Override any provisions in the replacing carrier's plan requiring the insured, subscriber or member to receive mental health services from mental health providers who have contracted with the replacing carrier to be part of the replacing carrier's provider network;

(3) Override any provisions in the replacing carrier's plan that reduce or eliminate benefits for mental health services whenever such services are received from a mental health provider who has not contracted to be part of the replacing carrier's network;

(4) Be provided to any insured, subscriber or member who, during an open enrollment period, changed from a benefit plan sponsored by the employer to another benefit plan sponsored by the same employer;

(5) Be subject to any provisions of the replacing carrier's plan requiring mental health services to be medically necessary, as defined in the replacing carrier's plan;

(6) Be subject to any provisions of the replacing carrier's plan requiring mental health services to be preauthorized by the replacing carrier or its utilization review agent;

(7) Be subject to the provision of proof of receipt of prior services while the prior carrier's plan was in effect as follows:

a. The insured, subscriber or member shall be responsible for providing such proof in the form of:

i. An explanation of benefits form from the prior carrier;

ii. A letter from the provider who provided the services attesting to the fact that services were provided together with the dates such services were rendered; or

iii. Any other documentation which the replacing carrier determines to be acceptable as proof; and

(8) Be subject to verification that the provider of services under the prior carrier is protected by a malpractice policy with coverage of at least $1,000,000 per single incident and at least $3,000,000 in the aggregate.

(d) While the entitlement provided pursuant to (b) above is in effect, benefits shall be paid by the replacing carrier as if the insured, subscriber or member were receiving mental health services from a mental health provider who has contracted with the replacing carrier.

(e) The replacing carrier shall not be required to make direct benefit payments to a non-network provider nor shall this provision operate in any way to increase the liability of the replacing carrier above what its liability would be if the mental health services were received from a contracting mental health provider who is reimbursed on a fee-for-service basis.

Source. #1900, eff 1-1-82; ss by #4287, eff 7-1-87; ss by #5655, eff 7-1-93; ss by #5945, eff 1-1-95

Ins 2201.12 Tax Exemptions. Health maintenance organizations which qualify as tax exempt organizations for federal income tax purposes under section 501(c) of the United States Internal Revenue

Code shall be considered tax exempt for the purposes of payment of premium taxes pursuant to RSA 420-B:17.

Source. #1900, eff 1-1-82; ss by #4287, eff 7-1-87; ss by #5655, eff 7-1-93;